		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023309

Facility Name: Calvin Johnson Care Center

Address: 727 North 17th Street (Number) Belleville (City) 62223 (Zip Code)

County: St. Clair

Telephone Number: 618-234-3323 **Fax #** 618-234-9477

IDPA ID Number: 37-1024089001

Date of Initial License for Current Owners: 04/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Read **Telephone Number:** 618-234-2273

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Steve Wolf
(Title) Executive Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	186	Skilled (SNF)	186	67,890	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	237	86,505	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,521	7,957	3,984	13,462	8
9	SNF/PED					9
10	ICF	42,884			42,884	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,405	7,957	3,984	56,346	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.14%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 2,658

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	218,333	21,094	15,393	254,820		254,820		254,820			1
2	Food Purchase		302,537		302,537		302,537		302,537			2
3	Housekeeping	275,510	27,577		303,087		303,087		303,087			3
4	Laundry	100,295	8,359	32,271	140,925		140,925		140,925			4
5	Heat and Other Utilities			222,380	222,380		222,380	2,223	224,603			5
6	Maintenance	74,926	31,559	31,467	137,952		137,952	3,172	141,124			6
7	Other (specify):*											7
8	**TOTAL General Services**	669,064	391,126	301,511	1,361,701		1,361,701	5,395	1,367,096			8
	B. Health Care and Programs											
9	Medical Director			17,124	17,124		17,124		17,124			9
10	Nursing and Medical Records	2,014,582	292,098	34,733	2,341,413	(430,951)	1,910,462		1,910,462			10
10a	Therapy	42,983		88,743	131,726	(30,326)	101,400		101,400			10a
11	Activities	53,904	8,651		62,555		62,555		62,555			11
12	Social Services	69,429		3,220	72,649		72,649	(880)	71,769			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,180,898	300,749	143,820	2,625,467	(461,277)	2,164,190	(880)	2,163,310			16
	C. General Administration											
17	Administrative	172,008		50,039	222,047		222,047	(50,039)	172,008			17
18	Directors Fees											18
19	Professional Services			2,329	2,329		2,329	8,040	10,369			19
20	Dues, Fees, Subscriptions & Promotions			41,712	41,712		41,712	(21,587)	20,125			20
21	Clerical & General Office Expenses	344,160	13,611	44,582	402,353		402,353	12,478	414,831			21
22	Employee Benefits & Payroll Taxes			393,716	393,716		393,716	34,658	428,374			22
23	Inservice Training & Education			57	57		57		57			23
24	Travel and Seminar			3,753	3,753		3,753	1,033	4,786			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,824	90,824		90,824	378	91,202			26
27	Other (specify):*			16,313	16,313		16,313	(16,313)				27
28	**TOTAL General Administration**	516,168	13,611	643,325	1,173,104		1,173,104	(31,352)	1,141,752			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,366,130	705,486	1,088,656	5,160,272	(461,277)	4,698,995	(26,837)	4,672,158			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Calvin Johnson Care Center #0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			87,834	87,834		87,834	6,414	94,248			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,238	60,238		60,238	(9,236)	51,002			32
33	Real Estate Taxes			41,766	41,766		41,766		41,766			33
34	Rent-Facility & Grounds			673,379	673,379		673,379	8,148	681,527			34
35	Rent-Equipment & Vehicles			206	206		206	3,758	3,964			35
36	Other (specify):*											36
37	**TOTAL Ownership**			863,423	863,423		863,423	9,084	872,507			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					461,277	461,277		461,277			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,757	129,757		129,757		129,757			42
43	Other (specify):*		13,657		13,657		13,657		13,657			43
44	**TOTAL Special Cost Centers**		13,657	129,757	143,414	461,277	604,691		604,691			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,366,130	719,143	2,081,836	6,167,109		6,167,109	(17,753)	6,149,356			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,845	30		9
10	Interest and Other Investment Income	(9,236)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,977)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,728)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(13,336)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,179)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Attached 5A	(1,355)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,966)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	28,213		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 28,213		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (17,753)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	Supplies Sold	X		142,055	10-2	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		13,748	10-3	42
43	Prescription Drugs	X		73,313	10-2	43
44	Exceptional Care Program	X		201,835	10-1-3	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule Therapy	X		30,326	10a-3	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 461,277		47

STATE OF ILLINOIS **Page 5A**

Calvin Johnson Care Center

ID# **0023309**

Report Period Beginning: **1/1/2001**

Ending: **12/31/2001**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber Shop Revenue	$ (880)	12	1
2	Chamber Fees	(475)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,223	0	0	0	0	0	0	0	0	2,223	5
6	Maintenance	0	0	3,172	0	0	0	0	0	0	0	0	3,172	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	5,395	0	0	0	0	0	0	0	0	5,395	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(880)	0	0	0	0	0	0	0	0	0	0	(880)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(880)	0	0	0	0	0	0	0	0	0	0	(880)	16
	C. General Administration													
17	Administrative	0	0	(50,039)	0	0	0	0	0	0	0	0	(50,039)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	8,040	0	0	0	0	0	0	0	0	8,040	19
20	Fees, Subscriptions & Promotions	(22,382)	0	795	0	0	0	0	0	0	0	0	(21,587)	20
21	Clerical & General Office Expenses	0	0	12,478	0	0	0	0	0	0	0	0	12,478	21
22	Employee Benefits & Payroll Taxes	0	0	34,658	0	0	0	0	0	0	0	0	34,658	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,033	0	0	0	0	0	0	0	0	1,033	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	378	0	0	0	0	0	0	0	0	378	26
27	Other (specify):*	(16,313)	0	0	0	0	0	0	0	0	0	0	(16,313)	27
28	**TOTAL General Administration**	(38,695)	0	7,343	0	0	0	0	0	0	0	0	(31,352)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,575)	0	12,738	0	0	0	0	0	0	0	0	(26,837)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	2,845	0	3,569	0	0	0	0	0	0	0	0	6,414	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,236)	0	0	0	0	0	0	0	0	0	0	(9,236)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,148	0	0	0	0	0	0	0	0	8,148	34
35	Rent-Equipment & Vehicles	0	0	3,758	0	0	0	0	0	0	0	0	3,758	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,391)	0	15,475	0	0	0	0	0	0	0	0	9,084	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,966)	0	28,213	0	0	0	0	0	0	0	0	(17,753)	45

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	30	Eldercare of Alton	Alton	Eldercare Inc	Belleville	Nur Home Mgt
Steve Wolf	50	Columbia Convalescent Center	Columbia			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-1	Home Office Prorate	$ 89,902	Eldercare Inc	0.00%	$ 89,902	$	1
2	V	21-1	Home Office Prorate	146,806	Eldercare Inc	0.00%	146,806		2
3	V	17-3	Home Office Prorate	50,039	Eldercare Inc	0.00%	78,252	28,213	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 286,747			$ 314,960	$ * 28,213	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Eldercare Inc	0.00%	$ 2,223	$ 2,223	15
16	V	6	Maintanance		Eldercare Inc	0.00%	3,172	3,172	16
17	V	17	Administrative	139,941	Eldercare Inc	0.00%	89,902	(50,039)	17
18	V	19	Professional Services		Eldercare Inc	0.00%	8,040	8,040	18
19	V	20	Fees,Subscriptions		Eldercare Inc	0.00%	795	795	19
20	V	21	Clerical&General	146,806	Eldercare Inc	0.00%	146,806		20
21	V	21	Clerical&General		Eldercare Inc	0.00%	12,478	12,478	21
22	V	22	Employee Benefits		Eldercare Inc	0.00%	34,658	34,658	22
23	V	24	Travel&Seminars		Eldercare Inc	0.00%	1,033	1,033	23
24	V	26	Ins. Prop		Eldercare Inc	0.00%	378	378	24
25	V	30	Depreciation		Eldercare Inc	0.00%	3,569	3,569	25
26	V	34	Rent Facility		Eldercare Inc	0.00%	8,148	8,148	26
27	V	35	Rent Equipment		Eldercare Inc	0.00%	3,758	3,758	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 286,747			$ 314,960	$ * 28,213	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Exec. Admin.	30.00	A 248966	19	38.00	Salary	$ 89,902	17-1	1
2											2
3											3
4											4
5											5
6			A Columbia Conv Center		169,403						6
7			Eldercare of Alton		79,563						7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 89,902		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Eldercare Inc
Street Address: 2620 W. Blvd.
City / State / Zip Code: Belleville, IL 6221-7208
Phone Number: (618-234-2273
Fax Number: (618-234-7777

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Direct Cost	11,629,339		$ 4,190	$	6,169,433	$ 2,223	1
2	6	Maintenance	Direct Cost	11,629,339		5,980		6,169,433	3,172	2
3	17	Administrative	Direct Cost	11,629,339		169,465	169,465	6,169,433	89,902	3
4	19	Professional Services	Direct Cost	11,629,339		15,156		6,169,433	8,040	4
5	20	Fees,Subscriptions	Direct Cost	11,629,339		1,498		6,169,433	795	5
6	21	Clerical&General	Direct Cost	11,629,339		276,729	276,729	6,169,433	146,806	6
7	21	Clerical&General	Direct Cost	11,629,339		23,521		6,169,433	12,478	7
8	22	Employee Benefits	Direct Cost	11,629,339		65,330		6,169,433	34,658	8
9	24	Travel&Seminars	Direct Cost	11,629,339		1,948		6,169,433	1,033	9
10	26	Ins. Prop	Direct Cost	11,629,339		712		6,169,433	378	10
11	30	Depreciation	Direct Cost	11,629,339		6,728		6,169,433	3,569	11
12	34	Rent Facility	Direct Cost	11,629,339		15,360		6,169,433	8,148	12
13	35	Rent Equipment	Direct Cost	11,629,339		7,083		6,169,433	3,758	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 593,699	$ 446,194		$ 314,960	25

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Union Planters		X	Open Line Of Credit	Demand	02/05/01	1,500,000	1,362,000	02/05/02	Prime	60,238	6
7												7
8												8
9	TOTAL Facility Related						$ 1,500,000	$ 1,362,000			$ 60,238	9
	B. Non-Facility Related*											
10				Interest Income							(9,236)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,236)	14
15	TOTALS (line 9+line14)						$ 1,500,000	$ 1,362,000			$ 51,002	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	44,724	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,026	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,698)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	43,464	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	41,766	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	36,726	8
1997	39,447	9
1998	41,124	10
1999	43,632	11
2000	43,026	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calvin Johnson Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0023309

CONTACT PERSON REGARDING THIS REPORT David Read

TELEPHONE 618-234-2273 FAX #: 618-234-7777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20.0-211-030	Nursing Home 4.18 Acres	$ 43,026.22	$ 43,026.22
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,026.22	$ 43,026.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,326 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories Two

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Bldg Imp			1982	600		10			600	9
10	1983 Audit			1983	4,085		10			4,085	10
11	Bldg Imp			1983	49,553		10			49,553	11
12	Black Top			1983	1,033		12			1,033	12
13	Remodeling			1984	7,160	358	20		(358)	7,160	13
14	Landscaping			1984	3,604		10			3,604	14
15	Windows			1985	1,454		10			1,454	15
16	A/C System			1985	1,983		8			1,983	16
17	Canopies			1985	6,333		10			6,333	17
18	Sidewalks			1985	7,800		15			7,800	18
19	Driveway Sealer			1985	810		5			810	19
20	Parking Stripes			1986	524		5			524	20
21	Renovate Halls			1988	21,660		10			21,660	21
22	Renovate Baths			1989	14,042		10			14,042	22
23	Roof Remodeling			1990	53,033	2,895	10-15y	3,045	150	43,916	23
24	Remodeling			1991	51,920	3,050	5-10y	3,164	114	37,714	24
25	Remodeling			1992	140,195	10,184	5-15y	10,449	265	100,165	25
26	Remodeling			1993	52,694	2,432	5-15y	2,432		20,999	26
27	Hall Monitor System			1994	3,208	204	15-20y	204		1,576	27
28	Improvements			1995	27,040	2,555	5-15y	2,785	230	19,138	28
29	Elevator			1996	4,929	689	15	329	(360)	1,449	29
30	Awnings			1996	4,195	420	10	420	(1)	2,205	30
31	Rooftop			1996	10,643	1,330	8	1,330	0	7,315	31
32	Renovations Paint/Wallpaper			1996	1,000		5			1,000	32
33	A/C Work & Carpeting			1997	7,032	869	5-15y	869		4,045	33
34	Fence			1998	1,250	156	8	156	0	624	34
35	Interior Renovation			1998	11,308	1,124	5-15y	1,124		3,976	35
36	Interior Renovation			1999	53,624	5,746	5-15y	5,746		14,577	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Cubicle Tracks	2000	$ 14,481	$ 965	15	$ 965	$ 0	$ 1,448	37
38	Renovations Interior	2000	12,015	1,202	10	1,202	(1)	1,803	38
39	Renovations Interior	2000	7,124	1,425	5	1,425	(0)	2,137	39
40	Landscaping	2000	21,213	2,121	10	2,121	0	2,651	40
41	Renovations Interior	2001	15,525	776	10	776	0	776	41
42	Renovations Interior	2001	45,895	2,295	15	1,530	(765)	1,530	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 658,965	$ 40,796		$ 40,072	$ (724)	$ 389,685	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 398,614	$ 42,860	$ 42,860	$	5-20yr	$ 198,471	71
72	Current Year Purchases	24,400	1,735	1,735		2-10yr	1,735	72
73	Fully Depreciated Assets	145,575					145,575	73
74	Loss on equipment		2,443	2,443				74
75	TOTALS	$ 568,589	$ 47,038	$ 47,038	$		$ 345,781	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1971 Bus	1977	$ 4,339	$	$	$		$ 4,339	76
77	Facility Use	1989 Olds Wagon	1992	8,550					8,550	77
78	Lift for Bus	Lift for Bus	1995	4,299					4,299	78
79	H.O. Depr					3,569	3,569			79
80	TOTALS			$ 17,188	$	$ 3,569	$ 3,569		$ 17,188	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,244,742	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,834	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,679	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,845	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 752,654	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Vending Machine 1980	$	$ 1,769	$ 1,769	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$ 1,769	$ 1,769	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93		N/A	93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Home, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1969	237	4/1/77	$ 673,379	20	20	3
4	Additions							4
5	H.O Lease				8,148			5
6								6
7	TOTAL		237		$ 681,527 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning 4/1/97
Ending 4/1/02

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ CPI index increase
13.	/2003	$ CPI index increase
14.	/2004	$ CPI index increase

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [X] NO

16. Rental Amount for movable equipment: $ 3,964 Description: Office & H.O. Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18		N/A			18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	186	$ 13,227	$	186	$ 13,227	1
2	Licensed Speech and Language Development Therapist		hrs		135	9,024		135	9,024	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		93	8,075		93	8,075	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				73,313		73,313	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program		8760	164,742	83	1,500	35,593	8,843	201,835	12
13	Supplies Sold Other (specify): Lab/X-Ray/Amb						142,055 13,748		142,055 13,748	13
14	TOTAL			$ 164,742	497	$ 31,826	$ 264,709	9,257	$ 461,277	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 63,611	$	1
2	Cash-Patient Deposits	54,303		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,084,232		3
4	Supply Inventory (priced at Cost)	39,355		4
5	Short-Term Investments			5
6	Prepaid Insurance	59,803		6
7	Other Prepaid Expenses	98,703		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,400,007	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	54,443		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	654,880		15
16	Equipment, at Historical Cost	587,546		16
17	Accumulated Depreciation (book methods)	(747,361)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 549,508	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,949,515	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 245,637	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,303		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,507		30
31	Accrued Taxes Payable (excluding real estate taxes)	54,785		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,464		32
33	Accrued Interest Payable	32,076		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	629		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 561,400	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,362,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Payable	682,169		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,044,169	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,605,569	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 363,946	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,969,515	$	48

***(See instructions.)**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 608,840	1
2	Restatements (describe):		2
3	**Prior Year Income Tax Adj**	(23,356)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 585,484	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(221,538)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (221,538)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 363,946	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,360,714	1
2	Discounts and Allowances for all Levels	10,284	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,370,998	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	123,371	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 123,371	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	17,222	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	135,629	17
18	Sale of Supplies to Non-Patients	262,802	18
19	Laboratory	22,764	19
20	Radiology and X-Ray	2,670	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 441,086	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,236	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,236	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Barber & Beauty Income	880	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 880	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,945,571	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,361,701	31
32	Health Care	2,625,467	32
33	General Administration	1,173,104	33
	B. Capital Expense		
34	Ownership	863,423	34
	C. Ancillary Expense		
35	Special Cost Centers	13,657	35
36	Provider Participation Fee	129,757	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,167,109	40
41	**Income before Income Taxes (line 30 minus line 40)****	(221,538)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (221,538)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. Return on extension**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,120	$ 53,456	$ 25.22	1
2	Assistant Director of Nursing	2,000	2,120	41,043	19.36	2
3	Registered Nurses	8,997	9,357	204,835	21.89	3
4	Licensed Practical Nurses	26,751	27,821	495,776	17.82	4
5	Nurse Aides & Orderlies	88,284	91,815	956,714	10.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,238	4,408	42,983	9.75	8
9	Activity Director	2,000	2,080	24,960	12.00	9
10	Activity Assistants	4,229	4,399	28,944	6.58	10
11	Social Service Workers	5,435	5,655	69,429	12.28	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	27,248	13.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,073	21,913	191,085	8.72	15
16	Dishwashers					16
17	Maintenance Workers	7,285	7,576	74,926	9.89	17
18	Housekeepers	36,198	37,638	275,510	7.32	18
19	Laundry	12,333	12,825	100,295	7.82	19
20	Administrator	1,980	2,100	82,106	39.10	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	89,902	86.44	22
23	Office Manager					23
24	Clerical	28,524	29,324	344,160	11.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: See attached	4,934	5,134	91,891	17.90	32
33	Other(specify) Resp Therapy	9,474	9,854	170,867	17.34	33
34	TOTAL (lines 1 - 33)	268,735	279,259	$ 3,366,130 *	$ 12.05	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	431	$ 11,193	1-3	35
36	Medical Director	165	17,124	9-3	36
37	Medical Records Consultant	34	1,453	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,020	10-3	39
40	Physical Therapy Consultant	868	36,145	10a-3	40
41	Occupational Therapy Consultant	556	21,926	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	346	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	94	3,200	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,165	$ 92,407		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,135	29,480	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,135	$ 29,480		53

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Ford	Administrator	0	$ 82,106
Steve Wolf	Exec. Admin	30	89,902
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 172,008

B. Administrative - Other

Description	Amount
Home Office Prorate	$ 50,039
TOTAL (agree to Schedule V, line 17, col. 3)	$ 50,039
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Flynn & Guyman	Legal	$ 263
Van Ostrand	Legal	584
SAMAS	Legal	71
P. Michael Read	Legal	1,098
Wessels & Pautsch	Legal	313
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,329

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,683
Unemployment Compensation Insurance	20,509
FICA Taxes	243,597
Employee Health Insurance	42,136
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	18,792
Home Office Payroll Taxes	34,658
TOTAL (agree to Schedule V, line 22, col.8)	$ 428,374

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,441
Health Care Worker Background Check	
(Indicate # of checks performed)	
Home office Dues&Fees	795
Ihca Dues	7,914
Dues & other licenses	2,901
Publications	1,118
Community Notices	1,757
Public Rel, Advertising, Chamber Dues	22,382
Less: Public Relations Expense	( )
Non-allowable advertising	(22,382)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,125

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,753
Home Office Seminars	1,033
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 4,786

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Calvin Johnson Care Center **#** 0023309 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $7914**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-15yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,480** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **No**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **129,757**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Calvin Johnson Care Center
Schedule XVIII A. Staffing

Line 32- Other Health Care	Hours Worked	Hours Paid	Reporting Pe Wages	Avg Hourly Wage
Insevice Nursing Direct	2000	2080	40560	19.50
Patient care Plan Coord	2934	3054	51331	16.81
	4934	5134	91891	17.90